Commonwealth of Kentucky

907 KAR 1:023E
Material Incorporated by Reference
(a) Technical Criteria for Reviewing Ancillary Services for Adults, NOV 2003 edition
(b) Technical Criteria for Reviewing Ancillary Servicesfro Pediatrics, NOV 2003 edition
(c) Form MAP-703, Request for Reconsideration of Ancillary Therapy Billing, APR 2000 edition.
Clean and Dirty

907 KAR 1:023E
(Review and approval of selected therapies as ancillary services in nursing facilities.)

Material Incorporated by Reference

Technical Criteria for Reviewing Ancillary Services for Adults, November 2003 edition

Technical Criteria for Reviewing Ancillary Services for Pediatrics, November 2003 edition

Form MAP-703, Request for Reconsideration of Ancillary Therapy Billing, April 2000 edition

Clean and Dirty

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, Kentucky 40621

Commonwealth of Kentucky

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November 2003 Edition

Technical Criteria for Reviewing Ancillary Services for Adults,
November 2003 edition

Technical Criteria for Reviewing Ancillary Services for Pediatrics,
November 2003 edition

Form MAP-703, Request for Reconsideration of Ancillary Therapy
Billing,
April 2000 edition

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, Kentucky 40621

I. PHYSICAL THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process shall employ the standards of practice developed by the American Physical Therapy Association.

B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Therapeutic exercise

   a. When exercising muscle or joint structure, the deficit requires a therapist's expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
   b. Progress is shown at predictable intervals.
   c. Gradual progression is from passive to fully active range of motion per situation and reasonable goal.

   Indication for Denial

   a. Lacks documented detail of dysfunction or goal.
   b. Goal seems unreasonable.
   c. Stability of resident questioned.
   d. Participation level a hindrance.
   e. Plateaued, goal achieved, or needs only repetitive range of motion for nursing care plan.
   f. Persistent flaccidity > 2—4 weeks in the focused area.

2. Cold Therapy

   a. Pain or spasm reduction or adjustment to range of motion exercise (repeated cycles).
   b. Trigger point use myofascial pain syndrome.
   c. Spasticity.

   Indication for Denial

   a. Response gain is not demonstrable.
   b. Performance is at nursing instructed level, and labile complex features.
   c. Inappropriate use in a vascular compromised setting (or labile or poor blood pressure control).
   d. Cold sensitivity disorder.

3. Low—Energy Laser

    a. Wound tissue healing.
    b. Pain management over trigger points.

    Indication for Denial

    a. Investigational.
    b. Effectiveness in rheumatoid arthritis questioned.

4. Transcutaneous Electric Nerve Stimulation (TENS)

    a. Post—operative incisional pain.
    b. Orthopedic analgesia acute or chronic, application to either trigger point or peripheral nerve.
    c. Chronic low back pain.
    d. Osteogenesis.
    e. Reflex sympathetic dystrophy (RSD).

    Indication for Denial

    a. Chronic radiculopathy pain.
    b. Cognitively impaired or unwilling to participate with schedule and safety factors.
    c. Unsafe application.
    d. Nursing is capable of managing (or resident can set—up, apply or control) after the initial evaluation of response or control setting is achieved.

5. Heat Therapy

    a. Active treatment of musculoskeletal mobility or pain problem as part of a therapist—driven treatment plan.
    b. In conjunction with an exercise regimen.

    Indication for Denial

    a. The active disorder is controlled, mostly for comfort.
    b. Complexity manageable by nursing.
    c. Resident is not responsive or is non-communicative.
    d. Ischemic limbs or other site or atrophic skin.

6. Ultrasound

   a. Joint contracture or scar tissue before friction massage, stretch, or range of motion (ROM) exercise (intensities and durations still need work), i.e., post—hip open reduction internal fixation.
   b. Reduce pain or muscle spasm.
   c. Trigger points.

   Indication for Denial

   a. Use in precautionary situations.
   b. Impaired sensitivity or ischemia.
   c. Questionable efficacy such as chronic herpes zoster, hemiplegic shoulder pain, fresh wound, or chronic pressure sore.

7. Hydrotherapy

   a. Facilitate assistive or resistive exercise.
   b. Removal of exudated or necrotic tissue.
   c. Reduce muscle spasm or pain.

   Indication for Denial

   a. General heat precautions.
   b. Treatment exposure using > 37 degrees centigrade in vascular impaired site.
   c. Absence of untoward effects or stable temperature tolerance and can be done by nursing staff.

8. Iontophoresis

   a. Antibiotic institution to avascular tissue.
   b. Medication for persistent post—surgical incision pain.
   c. Reduce inflammation or edema of musculosketetal (joints).

   Indication for Denial

   a. Anesthetic use (injection faster).
   b. Response lacking after reasonable interval.

9. Prosthesis

   a. Candidate has the capacity to use device.
   b. Candidate shows muscular strength, motor control, and range of motion adequate for gainful use.

   Indication for Denial

   a. Unteachable.
   b. Lacks items in 9-a and b.
   c. Poor wound healing.
   d. Other inappropriate conditions (such as bilateral, above-knee amputation over age 45, or below-elbow amputee or flail joint shoulder or elbow).
   e. Repetitive exercises that nursing care plan can accomplish pre—prothesis for stump shrinker use or prosthetic fitting.
   f. Repetitive use for distance or endurance only with level change having been achieved.
   g. Assisting routine care of equipment.
   h. Safety has been established so that the resident can perform trained exercise with supervision by nursing being the only need.

10. Electromyographic Biofeedback

   a. Spasticity or weakness as part of an acute cerebral vascular accident (CVA).
   b. Acute or chronic spinal cord injury.
   c. Multiple sclerosis with mild spasticity.

   Indication for Denial

   a. Absence of reasonable gain in the treatment plan time frame.
   b. Questionable effectiveness for the condition.
   c. Resident lacks voluntary control or motivation.

11. High Pressure Wound Irrigation

    a. Heavily contaminated wounds.

    Indication for Denial

    a. Clean proliferating wounds.
    b. Equipment or devices of questionable effectiveness or superiority to simpler devices.
    c. Nursing can provide equivalent service.

12. Hyperbaric Oxygen Wound Care

    a. Infected wounds or decubitus.
    b. Has reasonable circulation.

    Indication for Denial

    a. Advanced ischemic area.
    b. Potential for thromboembolism.
    c. Severe vasospasm.
    d. Lack of significant improvement in 4 weeks.

II. OCCUPATIONAL THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process shall employ the standards of practice developed by the American Occupational Therapy Association.

B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Therapeutic exercise

   a. When exercising muscle or joint structure the deficit requires a therapist's expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
   b. Progress is shown at predictable intervals.
   c. Gradual progression is from passive to fully active range of motion per situation and reasonable goal.

   Indication for Denial

   a. Lacks documented detail of dysfunction or goal.
   b. Goal seems unreasonable.
   c. Stability of the resident questioned.
   d. Participation level is a hinderance.
   e. Plateaued, goal achieved, or needs only repetitive ROM for nursing care plan.
   f. Persistent flaccidity > 2—4 weeks focused area.

2. Shared Modalities for Physical Therapy

   a. Heat therapy.
   b. Cold therapy.
   c. Prosthesis.
   d. Electromyographic biofeedback.

   Indication for Denial (see listings for Physical Therapy)

3. Functional Activities of Daily Living

   a. Feed.
   b. Dress.
   c. Bathe.
   d. Toileting.
   e. Grooming.

f. Cognition.

Indication for Denial

a. The condition prevents the individual from engaging in the technique or use of the device.
b. Technique is reached, resident or nursing staff can maintain activities for endurance, distance or repetition.
c. Chronic condition, therefore potential useful gain is questioned or minimal.
d. Unable to advance or use more complex dexterity level due to cognitive limits.
e. Biofeedback use in the presence of a prominent disorder. speech, language use, cognition or volitional ability (inability to follow festural or verbal instruction.
f. Coma stimulation - effectiveness questionable

III. SPEECH THERAPY: REVIEW FOR BILLING AS ANCILLARY

A. **STANDARDS OF PRACTICE:** The review process will employ the preferred practice patterns developed by the American Speech—Language—Hearing Association.

B. Deficiency of function must be of a significant level that an ancillary clinician s expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Treatment of Dysphagia (swallowing) Disorders

   a. Applicable diagnostic tests with confirmed abnormality (initial or progress recheck).
   b. Active teaching is appropriate for cognitive level (vs. delay till progress gain and provides alternative nutrition source).
   c. Uses specific postural, reflex facilitation, food placement, modified diet techniques with demonstrable progress.
   d. Prosthetic use.

   Indication for Denial

   a. Plateau, learned response, and repetitive exercise, reminders or prosthetics can be done by nursing as effectively.
   b. Confirmatory diagnostic test unavailable.
   c. Resident uncooperative or unreliable to safely use needed techniques.

2. Speech and Cognitive Disorders

   a. Tentative projected rehabilitation gain at the stage when cognitive level permits measurable change.
   b. Participation by resident required for repetitive or grouped exercises.
   c. Prosthetic training.
   d. Demonstrates there is no contributing significant auditory impairment.
   e. Use of nursing facility environment or staff to assist goals.

Indication for Denial

a. Inability to participate.
b. Plateau is reached in functional gain by measurable data or learned exercise and nursing can do repetitive technique.
c. Effectiveness of modality or participation level is in question.
d. Persisting active program beyond gain in condition having progressive deteriorating change or outlook (bilateral cerebral vascular accident, alzheimers).
e. Oral—nonverbal apraxia beyond 2 months.
f. Accompanying peripheral vision or hearing defects.

IV. OXYGEN THERAPY: REVIEW FOR MEDICAL NECESSITY

A. **STANDARDS OF PRACTICE:** The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association.

B. Technical abbreviations used in Item VII - Oxygen Therapy.
ABG - Areterial Blood Gases
AVF - Augmented Voltage Foot
O2 - Oxygen Level
paO2 - Partial Pressure of Oxygen
paCO2 - Partial Pressure of Carbon Dioxide
Oxygen Sats - Oxygen Saturation Levels
HCT - Hematocrit Level
mm Hg - Millimeters of Mercury

C. General Indicators.

1. Pa02 < 55 mm Hg or saturation < 88% while breathing ambient air.

2. Optimum medical management.

   a. Ancillary repiratory medications.
   b. Physiotherapy.
   c. Associated adverse conditions addressed.

3. PaO2 of 56-59 mm Hg or saturation of 91% in the presence of one or more of the following:

   a. Corpulmonale (p wave greater than 3 mm in standard leads II, III, or AVF).
   b. Right ventricular hypertrophy.
   c. Erythrocytosis (Hct > 56%).
   d. Reduced tissue oxygenation accompanied by neuropsych signs (i.e., tachycardia, tachypnea, dyspnea, cyanosis, diaphoresis chest pain or tightness, change in sensorium.

4. For that resident whose clinical condition prohibits evaluation of arterial oxygen saturation without supplemental oxygen:

   a. Oxygen saturation while on 02 < 92%.
   b. Pa02 < 60 mm Hg.

D. Continuous Oxygen

1. When hypoxemia criteria are established and met (found under general indicators) then continuous oxygen is appropriate.

2. Monitor clinical parameters (signs and symptoms associated with continuous oxygen needs).

3. Monitor results of oxygen therapy which measure functional improvement (i.e., ABF or oxygen Sats or improved symptoms).

E. Noncontinuous Oxygen

1. Documentation of clinically relevant hypoxemia related to exercise or nocturnal or sleeping even though "daytime resting" Pa02 or saturation may be adequate.

2. "As needed" (PRN) is generally not a valid reason to have available unless clinical documentation establishes hypoxemia and there exist circumstances why a person would not fit the category for continuous, exercise related, or sleep related.

F. Monitoring Condition

1. Acute use based on baseline Pa02/02 saturation and PaC02 in establishing initial oxygen dose.

2. The need for repeat use of ABG or oximetry depends upon the frequency the dose of oxygen is changed and/or the resident's altered clinical condition in response to therapy.

3. Use of ABG versus oximetry.

   a. Dependent on equipment available at facility or in area.
   b. Dependent upon the professionals available to secure arterial oxygen parameters and monitor or manage any subsequent condition.
   c. Dependent upon the arterial parameters needed.
   d. Oximetry is useful for non-hypercapneic persons as a guide to oxygen dose initation. It is simpler for nursing to utilize or log data. It is essentially nontraumatic for the resident (with few clinical complications). The data or results must be interpreted carefully per equipment variations applied (i.e., peripheral vascular disease). It may not correlate with Pa02 drawn in the same resident.

4. There are no criteria or resident requirements which fit all clinical situations to mandate ABG or oximetry testing for a stable resident. At least quarterly testing is advisable for the stable oxygen dependent condition. This is considered a reasonable interval to assess progress and establish continued need. More frequent may be warranted by physician judgment or changing clinical status. For the person with hypoxemia and hypercapnia establish regimen of oxygen or other treatment is suggested to be reassessed by ABG or oximetry every 1—2 months; again with exacerbation of illness of changing perameters of function closer monitoring intervals may be warranted.

G. Conservation of oxygen.

1. Devices in use that may be considered by treatment team or facility includes:

   a. Transtracheal oxygen delivery system.
   b. Reservoir mustache nasal prong.
   c. Reservoir pendant nasal system.

2. Adjusting up to 50% of the volume of oxygen delivered or used can be achieved with a decrease in overall expense but consideration has to be made for safety or complication in the transtracheal use. Also of note is the endurance or longevity factor associated with the pendant type product. It may not be as cost effective as the nasal prong as it is not as enduring.

I. PHYSICAL THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE- PEDIATRICS

A. **Standards of Practice:** The review process shall employ the standards of practice by the American Physical Therapy Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting program in presence of potential gain is documentable.

1. Therapeutic exercise/gross motor development program.

   a. Exercises are designed to utilize neuro developmental techniques, reflex integration, and perceptual-sensory motor integration to assist to reach the maximum potential possible. The Therapist's expertise is required to design, supervise or conduct a program in which there is a need for developmental or functional gain.
   b. Progress is demonstrated at predictable intervals.

   Indication for Denial

   a. Medically unstable.
   b. Goal seems unreasonable.
   c. Participation level questioned.
   d. Plateaued or achieved goals..
   e. Lacks documentation.

2. Chest Therapy-when respiratory therapy is not available.

   Postural drainage, including positioning to loosen secretions and promote drainage is within the training of the Physical Therapist. This is addressed with the bed fast, non-ambulatory or resident with pneumonia.

   Indication for Denial

   a. In-house Respiratory therapist.
   b. Managed by nursing/caregiver.
   c. Condition clinically stable and manageable by nursing/caregiver.

3. Equipment and/or orthopedic appliances assessed, fitted, adjusted and monitored. The pediatric resident utilizes equipment throughout his/her lifetime.

   a. Modify or monitor wheelchairs.
   b. Upon M.D. prescription, order, modify, monitor orthotic appliances. Work to train care givers and residents use of appliances. This includes, but is not limited to, braces, walkers, crutches, canes, oyster shells and back braces.

   Indication for Denial

   a. Unteachable.
   b. Repetitive use for distance or endurance.
   c. Resident can perform trained excersises.
   d. Nursing can monitor fit.
   e. Nursing can monitor maintenance of equipment of minor deficiencies/repairs.

4. Assessment to provide individualized, detailed documentation of the function of a particular child. This is generally performed at 6-12 month intervals or when change is indicated. Assessment may include, but is not limited to:

   a. Postural reflex integration.
   b. Status of sensory, motor, neuro motor and musculoskeletal systems.
   c. Perceptual motor development.
   d. Joint range of motion.
   e. Analysis of functional independence.
   f. Postural deviations.
   g. Gait analysis.
   h. Developmental level, including gross and fine motors.
   I. Adaptive equipment needs.
   j. Resident's and/or family needs.

   Indication for Denial

   a. Resident medically unstable.
   b. Lacks developmental maturation changes to justify reassessment.
   c. Lacks potential for gain.

5. Consultation and caregiver instructions are required as changes occur with the pediatric resident. Consultation to staff, such as nursing, respiratory therapy, classroom personnel, is needed to assist in the overall care. This consultation is needed in order to utilize the skills of the therapist for instruction and ongoing programming. This could include, but not limited to instruction for:

   a. Application of orthopedic appliances.
   b. Use of adaptive equipment
   c. Positioning.
   d. Routine exercises.
   e. Routine gait training.

   Indication for Denial

   a. Resident not able to participate medically.
   b. Lacks changes (regression or improvement) to justify consultation.
   c. Lacks potential for gain.
   d. Nursing/caregiver can provide modification.

6. Cold Therapy

   a. Pain or spasm reduction or adjustment to range of motion exercise (repeated cycles).
   b. Trigger point use myofascial pain syndrome.
   c. Spasticity.

   Indication for Denial

   a. Response gain is not demonstrable.
   b. Performance at nursing care plan level-routine program with no complex features.
   c. Inappropriate use in vascular compromised setting (or labile or poor blood pressure control).
   d. Cold sensitivity disorder.

7. Low-Energy Laser.

   a. Wound tissue healing.
   b. Pain management over trigger points.

   Indication for Denial

   a. Investigational.
   b. Efficacy in rheumatoid arthritis questioned.

8. Transcutaneous Electric Nerve Stimulation (TENS).

   a. Post-operative incisional pain.
   b. Orthopedic analgesia acute or chronic, apply to either trigger point or peripheral nerve.
   c. Low back pain chronic.
   d. Osteogenesis.
   e. Reflex sympathetic dystrophy (RSD).

   Indication for Denial

   a. Chronic radiculopathy pain.
   b. Cognitively impaired or unwilling to participate, with schedule and safety factors.
   c. Unsafe application.
   d. Nursing capable of managing (or resident can set-up, apply or control) after initial evaluation of response or control setting achieve.

9. Heat Therapy.

   a. Treatment actively of musculoskeletal mobility or pain problems as part of a therapist-driven treatment plan.
   b. In conjunction with exercise regimen.

   Indication for Denial

   a. Active disorder controlled, mostly comfort.
   b. Complexity manageable by nursing.
   c. Resident not responsive or non-communicable.
   d. Ischemic limbs or other site or atrophic skin.

10. Ultrasound.

    a. Joint contracture or scar tissue before friction massage, stretch, or range of motion (ROM) exercise (intensities and durations still need work), i.e. post-hip open reduction internal fixation.
    b. Reduce pain or muscle spasms.
    c. Trigger points.

    Indication for Denial

    a. Use in precautionary situations.
    b. Impaired sensitivity or ischemia.
    c. Questionable efficacy such as chronic herpes zoster, hemiplegic shoulder pain, fresh wound, or chronic pressure sores.

11. Hydrotherapy.

    a. Facilitate assistive or resistive exercise.
    b. Removal exudate or necrotic tissue.
    c. Reduce muscle spasm or pain.

    Indication for Denial

    a. General heat precautions.
    b. Treatment exposure using >37 degrees centigrade vascular impaired site.
    c. Absence untoward effects or stable temperature tolerance and can be done by nursing staff.

12. Iontophoresis

    a. Antibiotic institution to avascular tissue.
    b. Medication for persistent post-surgical incision pain.
    c. Reduce inflammation or edema musculoskeletal (joints).

    Indication for Denial

    a. Anesthetic use (injection faster).
    b. Response lacking reasonable interval.

13. Prosthesis.
    a. Resident has capacity to use device.
    b. Resident shows muscular strength, motor control, and range of motion adequate for gainful use.

Indication for Denial

a. Unteachable
b. Lacks above features.
c. Poor wound healing.
d. Other inappropriate conditions (such as bilateral above knee amputation over age of 45, or below elbow amputee and flail shoulder or elbow).
e. Repetitive exercises, and/or use of pre-prothesis stump shinker prior to prosthetic fitting can be carried as part of the nursing care plan.
f. Repetitive use for distance or endurance only and level change has been achieved.
g. Assisting routine care of equipment.
h. Resident can perform trained exercises with supervision by nursing.

14. Electromyographic Biofeedback.

    a. Spasticity or weakness as part of acute cerebral vascular accident (CVA).
    b. Acute or chronic spinal cord injury.
    c. Multiple sclerosis with mild spasticity.

Indication for Denial

a. Absence of reasonable gain in treatment plan time frame.
b. Conditions of questionable effectiveness.
c. Resident lacks voluntary control or motivation.

15. High Pressure Wound Irrigation.

    a. Heavily contaminated wounds.

    Indication for Denial

    a. Clean proliferating wounds.
    b. Equipment or devices of questionable efficacy of superiority to simpler devices.
    c. Nursing can provide equivalent service.

16. Hyperbaric Oxygen Wound Care.

    a. Infected wounds or decubitus.
    b. Has reasonable circulation.

    Indication for Denial

    a. Advanced ischemic area.
    b. Potential for thromboembolism.
    c. Severe vasospasm.
    d. Lack of significant improvement in 4 weeks.

II. OCCUPATIONAL THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE-PEDIATRICS

A. **Standards of Practice:** The review process shall employ the standards of practice developed by the American Occupational Therapy Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting the program in the presence of potential gain is. documentable. Uniform terminology of Occupational Therapy developed by the American Occupational Therapy Association shall be used to define deficiency of function.

1. Therapeutic activities shall address appropriate Occupational Therapy performance areas of:

   Activities of daily living.
   Work activities.
   Play or leisure activities.

   Treatment in each performance area shall address specific performance components. These performance components consist of

   Sensory Motor Skills.
   Cognitive Skills.
   Psychological Skills.

   (Please refer to attached copy of uniform terminblogy for Occupational Therapy definitions of performance areas and performance components.)

   a. Implementation of therapeutic activities requires a therapists' expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
   b. Progress is shown at predictable interval for remediation of dysfunction where appropriate.
   c. Compensatory and prevention intervention models are also utilized in treatment of individuals with chronic conditions and developmental disabilities. This may include adaptive equipment, technology, graded assistance, and task modification. Documentation of outcomes shall reflect progress in function in performance areas and performance components.

Indication of Denial

a. Lacks documented details of dysfunction or goal.
b. Stability of resident questioned.
c. Participation level a hindrance.
d. Unreasonable goal.
e. Plateaued, goal achieved, or needs only repetitive ROM, ADL coaching, or ustimulationn environment as by nursing care plan.
f. Adaptive equipment lacks usable functionality.
g. Nursing/caregiver can provide preventativelcompensatory techniques for ongoing application.

2. Activities of Daily Living

a. Grooming.
b. Oral Hygiene.
c. Toilet Hygiene.
d. Dressing.
e. Feeding and eating.
f. Medication routine.
g. Socialization.
h. Functional mobility

Highest level of function shall be consistent with developmental levels. Prerequisite' skills in identified performance areas shall be targeted and progress documented, including use of compensatory strategies and adaptive equipment When a plateau is reached, periodic re-evaluation are allowed and the ancillary clinician may resume treatment program if resident shows documented changes in function in performance area and performance components. Updating and progressing the activities of daily living program requires the expertise of the ancillary clinician and periodic program update with care-giver instruction are allowable.

Indication of Denial

a. Condition prevents engaging techniques or use of device.
b. Technique learned, resident or nursing staff can carry-out routinely.
c. Chronic condition limits functional gain-documentation shows failure of prescribed technique over reasonable time span.
d. Unable to advance or use more complex dexterity level due to cognitive limits-documentation shows failure of compensatory strategies over reasonable time span.

3. Splinting and fabrication/prescription for adaptive equipment/environments.

a. Fabrication and fitting of splints and adaptive devices restore function in neuromuscular and/or motor performance components to support highest practicable level of function as part of intervention plan.
b. Therapist shall document prescribed use of splints or devices and instruct caregiver
c. Therapist shall monitor, fit and repair splint or device and periodically make necessary modifications for fit, safety and changes in function.
d. Design of adaptive equipment and environment to improve function in performance areas and specified performance components that requires expertise of an ancillary clinician. Include safety devices and restraint alternatives in keeping with OBRA guidelines for restraint free environments.

Indication for Denial

a. Documentation does not support need.
b. Use of splint/device/environment incorporated into routine and nursing care plan (re-evaluation and modification by Occupational Therapist are allowable when changes in function occur.)

4. Consultation and Care-Givers Instruction
Consultation with care-givers shall be provided to establish consistency with nursing care plan and to prepare for discharge.

a. Clinically relevant deficiencies are present.
b. Potential gain is evident
c. The resident demonstrates developmental maturation changes that need ancillary OT input.

III. SPEECH THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE-PEDIATRICS

A. Preferred practice patterns for professions of Speech-language Pathology and Audiology shall be those developed by the American Speech and Hearing Association.

B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting program in presence of potential gain, or, as a preventative measure, is documentable.

1. Speech (articulation, fluency, voice), Language and Cognitive Disorders.

   a. Utilization of standardized testing measures.
   b. Treatment is conducted to achieve improved, altered, augmented, or compensated speech, language and cognitive communication behaviors or processes.
   c. Treatment may include prerequisite skill training which includes, but not limited to cooing, respiratory support for vocalization, oral stimulation, vocal turn taking, inflection, object permanence, cause and effect knowledge, problem-solving, gesturelsign.
   d. Prosthetic/adaptive device training (e.g. speaking valve, adaptive switch, adapted toys, etc.)
   e. Equipment maintenance at interval consistent with:

      1. Physical and/or developmental change.
      2. New equipment problem beyond nursing/caregiver expertise.

   Indication for Denial

   a. Standardized and nonstandardized measures reveal age appropriate speech-language and cognitive skills.
   b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and the annual speech-language evaluation.

2. Oral pharyngeal function (dysphagia) and related disorders.

   a. Applicable diagnostic testing with confirmed abnormality.
   b. The absence of, or restricted oral presentation of food and/or liquids.
   c. Strategies that alter behavior (e.g., posture, rate, learned airway protection measures, method of intake, prosthetic use, etc.)
   d. Modification of swallowing activity in coordination with respiratory or alternation of bolus characteristics (e.g. volume, consistency).
   e. Equipment maintenance at interval consistent with:

      1. Physical and/or developmental change.
      2. New equipment problem beyond nursing/caregiver expertise.

   Indication for Denial

   a. Standardized tests, observations, instrumental diagnostic procedures, structural assessment and functional assessment reveal normal parameters of the swallow system and other oral pharyngeal functions.
   b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and the annual speech-language evaluation.
   c. Lack new equipment problem.
   d. Nursing/caregiver can perform maintenance/repair.
   e. Lack of nursing/caregiver training.

3. Augmentative and Alternative Communication (AAC) Systems.

   a. Training of prerequisite skills for AAC includes, but not limited to visual attention, visual tracking, choice making activities, cause and effect knowledge and anticipation of outcome.
   b. Determination of the MC intervention program (assessment).
   c. Selection and the development of an effective AAC system.
   d. Service implementation and system integration into the natural environment. Includes care-giver training.
   e. Follow-up and ongoing evaluation.
   f. Equipment maintenance at interval consistent with:

      1. Physical and/or developmental change.
      2. New equipment problem beyond nursing/caregiver expertise.

Indication for Denial

a. Standardized and nonstandardized measures reveal age appropriate speech-language skills, utilizing AAC.
b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and annual speech-language evaluation.
c. Lack new equipment problem.
d. Nursing/caregiver can perform maintenance repair.
e. Lack of nursing/caregiver training.

4. Aural Habilitation/Rehabilitation.

a. Comprehension and production of language in oral, augmentative, signed or written modalities.
b. Speech and voice production.
c. Auditory training.
d. Speech reading.

Indication for Denial

a. Audiological assessment reveals adequate hearing acuity.
b. Standardized and nonstandardized measures reveal age appropriated speech-language and cognitive skills. U,
c. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and annual speech language evaluation.
d. Lack new equipment problem.
e. Nursing/caregiver can perform maintenancelrepair.
f. Lack of nursinglcaregiver training.

5. Consultation and care Giver Instruction

a. Consultation and caregiver instructions are required as changes occur with the pediatric resident. Consultation to staff, such as nursing, respiratory therapy, classroom personnel, is needed to assist in the overall care. This consultation is needed in order to utilize the skills of the therapist for instruction and ongoing programming, taking into consideration:

1. Clinically relevant deficiencies.
2. Potential gain.
3. Demonstrable developmental maturation changes that require ancillary ST input.

Indication for Denial

a. Resident not able to participate medically.

IV. OXYGEN THERAPY: REVIEW FOR MEDICAL NECESSITY

A. Standards of Practice. The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association. The pediatric criteria not found here shall be based on age appropriate parameters obtained from current textbook baselines.

Technical abbreviations used in item IV-Oxygen Therapy:

1. ABG-Arterial Blood Gases;
2. AVF-Augmented Voltage Foot;
3. 02- Oxygen Level;
4. PaO_2 -Partial Pressure for Oxygen;
5. $PaCO_2$ -Partial Pressure of Carbon Dioxide;
6. Oxygen Sats-Oxygen saturation levels;
7. HCT-Hematocrit Level; and
8. $_{mm}$ Hg- Millimeters of Mercury

C. General Indicators

1. Oxygen saturation < 93% or PaO_2 <65 $_{mm}$ Hg while breathing room air.
2. Optimum medical management.
   a. Ancillary respiratory medications.
   b. Physiotherapy.
   c. Associated adverse conditions addressed.
3. PaO2 of 56-59 mm Hg or saturation of 91 percent in the presence of one or more of the following:
   a. Cor pulmonale (p wave greater than 3mm in standard leads II, III, or AVF).
   b. Right ventricular hypertrophy.
   c. Erythrocytosis (Hct >56 percent).
   d. Reduced tissue oxygenation accompanied by neuropsych signs (i.e., tachycardia, tachypnea, dysnea, cyanosis, diaphoresis chest pain or tightness, change in sensorium.)

4. For that resident whose clinical condition prohibits evaluation of arterial oxygen saturation without supplemental oxygen:

   a. Oxygen saturation <95% or PaO_2 <65 mm Hg while breathing oxygen. Monitor functional improvement resulting from oxygen therapy (e.g., oxygen saturation, PaO_2, symptomatic improvement.

D. Continuous Oxygen

1. When hypoxemia criteria are established and met (found under general indicators) then continuous oxygen is appropriate.

2. Monitor clinical parameters (signs and symptoms associated with continuous oxygen needs).

3. Monitor results of oxygen therapy which measure functional improvement (i.e., ABG or oxygen sats or improved symptoms).

E. Noncontinuos Oxygen

1. Documentation of clinically relevant hypoxemia related to exercise or nocturnal or sleeping even though "daytime resting" PaO2 or saturation may be adequate.

2. "As needed" (PRN) is generally not a valid reason to have oxygen available unless clinical documentation establishes hypoxemia and there exist circumstances why the person would not fit the category for continuous oxygen or, exercise related or sleep related non-continuos oxygen. An exception is made for brittle pediatric residents who have a significantly decreased PaO_2 with feeding, communication, or crying.

F. Monitoring Condition

1. Acute use based on baseline PaO_2 or O_2 saturation and $PaCO_2$ in establishing initial oxygen dose.

2. The need for repeat use of ABG or oximetry depends upon the frequency the dose of oxygen is changes or changes in the resident's clinical condition in response to therapy.

3. Use of ABG versus oximetry.

   a. Dependent on equipment available at facility or in area.
   b. Dependent upon the professionals available to secure arterial oxygen parameters and monitor or manage any subsequent conditions.
   c. Dependent upon the arterial parameter needed.
   d. Oximetry is useful for non-hypercapnic persons as a guide to oxygen dose initiation. It is simpler for nursing to utilize or log data. It is essentially non-traumatic for the resident (with few clinical complications). The data or results must be interpreted carefully per equipment variations applied (i.e., peripheral vascular disease). It may not correlate with $PaCO_2$ drawn in the same resident.

4. There are no criteria or resident requirements which fit all clinical situations to mandate ABG or oximetry testing for a stable resident. At least quarterly testing is advisable for the stable, oxygen dependent condition. This is considered a reasonable interval to assess progress and established continued need. More frequent testing may be warranted by physician judgment or changing clinical status. For the person with hypoxemia and hypercapnia, the established regimen of oxygen or other treatment is suggested to be reassessed by ABG or oximetry every 1 to 2 months. With exacerbation or illness of changing perimeters of function, closer monitoring intervals may be warranted.

G. Conservation of oxygen.

1. Devices in use that may be considered by the treatment team or facility includes:

   a. Transtracheal oxygen delivery system.
   b. Reservoir mustache nasal prong.
   c. Reservoir pendant nasal system.

2. Adjusting up to 50 percent of the volume of oxygen delivered or used can be achieved with a decrease in overall expense but consideration has to be made for safety or complication in the transtracheal use. Also of note is the endurance or longevity factor associated with the pendant type product. It may not be as cost-effective as the nasal prong as it is not as enduring.

MAP-703 (rev. 04/2000)

Request for Reconsideration
Ancillary Therapy Billing

A nursing facility that disagrees with the Healthcare Review Corporation's denial for ancillary therapy billing may request a reconsideration. All facility requests for reconsideration will be made in writing using this form, within seven (7) days of the date the facility is notified that a selected ancillary therapy modality has not been approved by the review agency.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Facility Name: ______________________________

Facility Medicaid Provider Number: ______________________________

Facility Telephone Number: ______________________________

Facility Address: ______________________________

____

Resident's Name: ______________________________

Resident's Medicaid Number: ______________________________

Effective Date of the Denial: ______________________________

IN ORDER TO ESTABLISH A BASIS FOR RECONSIDERATION:

1) Enclose a copy of the resident Ancillary Services Nursing Facility Determination form.

2) Write a brief description of the basis for your disagreement with the denial. (Attach rationale to this form.)

3) Attach documentation establishing that the needs of the resident at the time of the denial justify ancillary therapy billing.

I signify by my signature that these statements are correct and factual to the best of my knowledge.

Signature: ______________________________ Date: ______________

Title: ______________________________

Mail to: Attn: Field Review Supervisor
Healthcare Review Corporation
9200 Shelbyville Rd., Ste. 700
Louisville, KY 40222